TESTIMONY OF

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on

PREVENTING MEDICARE FRAUD

before the

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GOVERNMENT MANAGEMENT, INFORMATION & TECHNOLOGY

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Chairman Horn, Congressman Turner, Congresswoman Biggert, distinguished subcommittee members, thank you for inviting us to discuss our efforts to prevent fraud and keep unscrupulous providers out of the Medicare program and the Medicare Fraud Prevention and Enforcement Act, H.R. 3461. Safeguarding the Medicare program's interests is one of our highest priorities, and we greatly appreciate your interest and support.

We have made great strides in improving program integrity in the past several years. We have been aided immeasurably in these efforts by the findings of the CFO audit and payment error estimation that legislation from this Subcommittee requires the HHS Inspector General to conduct each year. Lessons learned are helping us to continually build upon our success and bolster our zero tolerance policy for fraud, waste, and abuse.

Among the lessons learned are

- the importance of systemic risk assessment to identify potential problems and program vulnerabilities;
- the ability of technology solutions to help us find and fight fraud;
- the usefulness of surveys and site visits to increase our assurance that billers are qualified and legitimate; and,
- the importance of reaching out to our partners—beneficiaries, providers and other Federal and State agencies—to gain their participation in our efforts to protect the integrity of the Medicare trust fund.

These lessons are incorporated into our Comprehensive Program Integrity Plan, and are helping us to reduce improper payments and keep questionable entities from billing the program.

Congresswoman Biggert, we appreciate your support, and the Medicare Fraud Prevention and Enforcement Act specifically. Your bill would authorize and strengthen the actions we have taken to implement the lessons we have learned. We look forward to working with you to prevent unscrupulous providers from entering the program, and to removing those who may already be defrauding the program at the taxpayers' expense.

BACKGROUND

In February 1999, we released our Comprehensive Plan for Program Integrity. Its development began two years ago when we sponsored an unprecedented national conference on fraud, waste, and abuse in Washington, D.C. Groups of experts from private insurers, consumer advocates, health care provider groups, state health officials and law enforcement agencies were invited to share successful techniques and explore new ideas. We synthesized and analyzed their discussions to determine the most effective strategies and practices already in place, and the new ideas that deserved further exploration. The result was a Comprehensive Program Integrity Plan with ten priorities. These priorities included:

- ***Increasing the Effectiveness of Medical Review and Benefit Integrity Activities***. Medical review activities, where we review medical records to ensure that claims are correct, include all actions taken by contractors to determine whether a particular service was medically necessary, properly coded, and documented. Benefit integrity activities, such as data analysis and complaint investigation, allow us to identify and pursue billers suspected of outright fraud.
- ***Implementing the Medicare Integrity Program***. This allows us to hire special contractors who focus solely on program integrity, as authorized under the Health Insurance Portability and Accountability Act. Until now, only insurance companies who process Medicare claims have been able to conduct audits, medical reviews, and other program integrity activities. Under the new authority, we can and have started to contract with many more firms who can bring new energy and ideas to this essential task.
- ***Proactively Addressing the Balanced Budget Act***. The BBA created several new programs, benefits, and payment systems. We continue to work to address potential program integrity problems these changes could raise before they occur.
- ***Promoting Provider Integrity***. We have made clear that we do not simply pay bills, but enter into agreements to do business with providers. We have stepped up efforts to educate providers on how to comply with program rules; supported the development of compliance plans; increased the number of onsite visits we make; and are working to publish a proposed regulation to establish clear enrollment requirements, including conditions under which we will deny or revoke billing privileges.
- ***Focusing on specific parts of the program.*** These include inpatient hospital care, managed care, nursing homes, and community mental health centers. We have focused on these areas to reduce payment errors and ensure protection of beneficiaries.

We are committed to continuing our success and expanding it at every opportunity.

For the remainder of my testimony, I would like to focus on our efforts to promote provider integrity, and specifically talk about our provider/supplier enrollment processes. These are the subjects of a good part of the Medicare Fraud Prevention and Enforcement Act, and our activities and accomplishments to date may interest you.

Purpose of Provider Enrollment

The primary purpose of provider enrollment is to ensure that only qualified and legitimate providers, suppliers and physicians obtain billing privileges. Secondarily, we use our provider enrollment process to obtain needed information about payment and mailing instructions so that claims are processed and payments are made correctly. We collect a wide variety of information through the varying programs we

administer. We continue to ensure the privacy and security of sensitive information. Additionally, the Department's privacy rule is scheduled to be finalized this year, which will further bolster the protection afforded to sensitive information.

The best provider enrollment process is one in which all applicants are successfully processed into the program, because unqualified or illegitimate individuals never bother to apply, knowing they will be rejected. Thus, the enrollment process must balance two competing needs: (1) the need for sufficient scrutiny to provide a effective deterrent to enrollment attempts from unqualified or illegitimate individuals (and detect them if they attempt enrollment) and (2) the need to make the process as administratively simple as possible and reduce burden on qualified, legitimate individuals and businesses seeking to bill the program.

To accomplish this, we use a three step approach, in which we:

- Collect key information that uniquely identifies the provider or supplier and requires them to identify where they will render services, whom their owners and managers are, and to submit proof of their qualifications to render health care along with pertinent data to establish claims payment. Since 1996, we collect this information on a standard, national enrollment form, and under penalty of law, providers and suppliers attest to the accuracy of the information they have provided.
- Conduct a data validation process, involving a variety of different data sources. Increasingly, the Internet has become a useful source of information to help validate information such as addresses. We also check licensing boards, sanction and debarment lists, and the new Healthcare Integrity and Protection Data Bank (HIPDB), a national health care fraud and abuse data collection program for reporting and disclosing certain final adverse actions taken against health care providers, suppliers, or practitioners.
- May also conduct site visits if a State survey (to ensure compliance with conditions of participation) has not been conducted, or if the entity or organization has not been subject to an accreditation by an approved accreditation authority (such as the Joint Commission on Accreditation of Healthcare Organizations). These are now conducted on all newly enrolling durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) entrants, independent diagnostic testing facilities, and community mental health centers. Contractors also have the flexibility to conduct site visits in other areas if they suspect problems might exist, based on beneficiary complaints, tips from State agencies or authorities, or ongoing and completed investigations.

I would like to discuss some of these efforts in more detail, particularly focusing on areas where we found significant vulnerabilities.

Durable Medical Equipment

Durable medical equipment (DME) was one of the very first areas we targeted in our increased efforts to fight fraud, waste, and abuse. Medicare pays some $6 billion each year for wheelchairs, canes, and other durable medical supplies. But investigations by the HHS Inspector General found that a significant number of DME suppliers did not have physical business addresses, or were located in private homes, or had no actual supply of equipment to provide.

To respond to this problem, we took a number of steps. First, we increased the standards for DME suppliers. Since there was little to no State licensing of DME suppliers, we needed to step in and make

sure that basic business requirements—such as honoring warranties, maintaining and repairing equipment, accepting returns, maintaining a physical facility on an appropriate site, maintaining liability insurance—were met by suppliers doing business with Medicare. Second, we established the National Supplier Clearinghouse, a national enrollment contractor for suppliers furnishing durable medical equipment, prothestics, and orthotics. Third, we authorized site visits for all newly enrolling and reenrolling suppliers.

These activities have increased our assurance that suppliers doing business with Medicare are legitimate and qualified. In fiscal years 1998 and 1999, the National Supplier Clearinghouse conducted tens of thousands of site visits. While we are happy to report that the vast majority of applicants past muster, about 500 did not. Since these 500 suppliers could not even pass the basic screen of a site visit, they do not belong in the Medicare program, and should not receive Medicare funds.

The National Supplier Clearinghouse has been so effective that we have heard stories of fraud perpetrators "giving up" on getting to the program through the supplier enrollment process.

Community Mental Health Centers

As part of Operation Restore Trust, we began identifying patterns of fraud and abuse at community mental health centers (CMHC). We, along with the HHS Inspector General, found providers enrolled in Medicare who were not qualified to deliver psychiatric services, patients enrolled who were ineligible for the Medicare benefit, and services inappropriately billed to Medicare. In September 1998, we announced new actions to ensure that Medicare beneficiaries with acute mental illness receive quality treatment in CMHCs and that Medicare pays appropriately for those services. In 1999, we charged one of our Medicare Integrity Program contractors with conducting unannounced site visits for all new CMHC applicants to ensure that they provide all the services required for Medicare enrollment.

While these measures helped to reduce inappropriate reimbursements by removing unqualified providers, we also began intensified medical reviews of CMHC partial hospitalization services, with particular emphasis on States targeted in the Inspector General’s October 1998 audit report. In those five States (Florida, Texas, Colorado, Pennsylvania, and Alabama), over 90 percent of CMHC partial hospitalization program claims in those states did not meet Medicare coverage requirements. So we directed our contractors for those areas to review 30 percent of every CMHC provider's claims, and then adjust review levels depending on results.

The President’s FY 2001 budget includes several legislative proposals to strengthen and clarify the partial hospitalization benefit and reduce its misuse. Those proposals would create civil money penalties for false certification of a beneficiary’s need for the benefit, prohibit partial hospitalization services from being furnished in a beneficiary’s home or other residential setting, and take other steps to prevent abuse of the Medicare program.

Another longstanding issue requiring legislation involves the statutory requirement that, to participate in Medicare, a CMHC must perform screening for admissions to State psychiatric facilities. Some State laws or regulations limit this function to designated facilities. As a result, many CMHCs in those States cannot meet the federal requirement. Up to this point, we have not pursued termination actions against CMHCs that are out of compliance with this requirement alone. While legislation has been introduced to modify this requirement, it has yet to become law.

Independent Diagnostic Testing Facilities

In another area, we found that entities that billed for and/or provided diagnostic tests often were not legitimate businesses or did not meet reasonable quality standards. To eliminate this problem, we took a page out of our successful durable medical equipment, prosthetics, orthotics, and supplies effort. We produced a regulation establishing new, higher standards for entry into the program, and told all existing entities that they had to re-enroll into the program, showing that they met the new requirements. We conducted site visits as part of this effort. In the end, only about half of the entities previously enrolled in the program successfully re-enrolled. Many did not bother to apply for re-enrolment.

Other Site Visits

Of course, our purpose here is not to prevent enrollment by qualified entities or individuals. The drops that we have seen in the number of DME suppliers, CMHCs, and IDTFs were all accompanied by surveillance strategies to ensure that beneficiary access was not impaired—to make sure that we had not raised the bar so high that we were keeping out good providers as well as bad ones. Again, it is a balancing act, and we try hard to get it right.

The last point I will make about site visits is the importance of some local flexibility, based on local knowledge, to conduct site visits where they are most needed. I heard one story from one of our contractors about their site visits to a very specific kind of applicant: physicians over 70 who were enrolling to bill Medicare for the first time. The fraud unit knew of cases where physicians' identities were being used as fronts for illegal medical services, sometimes by relatives without the physician even knowing. As a result, this contractor flagged those enrollments, and conducted site visits to such physicians. They report that it was a worthwhile effort, uncovering some highly questionable circumstances leading to referrals for fraud investigation.

Future Efforts

We plan to propose a new regulation on provider and supplier enrollment this summer, and are currently developing a national database to include extensive information on providers as they enroll in our program. Under this program, we would not issue a billing number in cases where a provider or supplier has been excluded from Medicare, is currently under Medicare payment suspension, has unpaid Medicare debts, or has been convicted of a felony inconsistent with the interest of the Medicare program. Our proposed rule will provide the public a chance to offer additional comments or suggestions for the provider enrollment regulations.

Once the proposed rule is finalized, we will begin an enrollment clean up process. As part of this process, we will go back to providers and suppliers now billing the program and require them to confirm and update their information periodically, including data on their billing arrangements. Information collected will be entered into a new enrollment system, which is known as the Provider Enrollment, Chain, and Ownership System (PECOS).

PECOS will be a central source of provider/supplier enrollment information. In addition to chain ownership and related organization information, it will include information on providers' billing arrangements and any reassignment of benefits. The chain organization/related organization information will allow contractors to identify when a provider or supplier is part of a larger organization, and to view their entire line of business. PECOS also will permit a local contractor to view national data about an individual or entity, rather than simply the data that appears on a local provider file. And PECOS will identify providers and suppliers who have been denied privileges, or are subject to revocations or

exclusions. By offering a more complete picture of provider business operations, PECOS should help to ensure Medicare works only with reputable business partners. Our current schedule calls for PECOS to be up and running for Fiscal Intermediaries this September, with Carriers following in January 2002. I will now to turn to a few other issues that are taken up by the Medicare Fraud Prevention and Enforcement Act.

Third Party Billing Agents

Third party billing companies that operate ethically can provide a valuable service to providers and suppliers who seek out their help in submitting claims correctly and efficiently. These firms vary greatly, performing a wide variety of services from simply formatting claims for submission to Medicare and private insurance companies to managing the entire "business end" of provider practices.

Improper third party billing practices can pose a significant threat to Medicare. Billing companies that engage in behavior that gives rise to false claims can be held accountable under the False Claims Act. Under current regulations, we review these arrangements only when new Medicare providers or suppliers ask that their payments be made to an agent. These reviews have led to an increase in the number of third party billing contracts that are in compliance with existing laws and regulations. However, when billing companies assist in preparing bills or coding, but do not actually receive payment, they generally are not regulated. Billing arrangements for providers who entered the program before 1996 are not reviewed, and our overall ability to monitor third party billing practices is quite limited.

The new enrollment regulations and a new enrollment database for all providers, mentioned above, should solve some of these problems. The new system will specifically gather information on third-party billing companies. The new enrollment regulations will require providers to periodically update information, including their billing arrangements. And, in publishing the provider enrollment regulation proposal, we intend to invite public comments on how to address challenges in better oversight of third party billing companies.

Additionally, problems identified by us, the IG, and the General Accounting Office make clear that we may need to do even more. In follow up to a hearing by the House Commerce Committee, we organized a summit, bringing together billing agents, congressional staff, the GAO, and the IG to discuss how best to respond to the threats posed by unscrupulous third party billers. This summit allowed us to understand better the costs and benefits of collecting additional information, the challenges of defining "third party billing agent," and the difficulty of changing electronic claims submission standards to create audit trails. However, it also was clear that the billing agent community was willing and eager to work with us on the issue.

Limiting Bankruptcy Debt Discharge

We strongly support preventing fraudulent providers from using bankruptcy protection as a way to dodge responsibility for repaying overpayments, fines, or penalties. In the past, we have proposed HCFA authority to ensure that when providers declare bankruptcy in order to avoid an overpayment, penalty, or fine resulting from fraudulent behavior, the Medicare program can recoup those overpayments and fines. There are instances where providers owing the Medicare program millions of dollars in overpayments declare bankruptcy as soon as corrective actions are taken against them, and the public ends up swindled out of millions of dollars. Limiting debt discharge would help to increase the accountability of individuals and entities providing Medicare and Medicaid services, and we very strongly support

enacting this into law.

Excluded Providers

Clearly, we must make sure payments do not go to excluded providers, and we are now developing a better system to make sure they do not. Our enrollment regulation will require this sort of information and will allow contractors to weed out the providers who do not belong in the program. However, we do not at this time support holding Medicare contractors financially liable for erroneous payments to individuals and entities that have been excluded from the program.

First, we do not believe this is a significant problem. A recent IG report sent to us estimated $30,000 in losses in 1997 due to improper payments to excluded providers. And we believe the contractors are making a good faith effort to prevent such payments. Contractors have not always been given all the data they need to prevent them. The existing database of excluded providers can be unwieldy for the contractors to employ in their provider enrollment and claims processing operations, and critical data needed by the contractors are missing from many records. Working with the IG and our contractors, we have identified ways to improve our system for preventing such payments. We are now developing a new system that includes a significantly improved database on excluded providers. We will check that database against files of providers billing Medicare and against databases with employment information. That will help prevent excluded individuals and entities from re-entering the program, and will work much better than our current system.

We would like to note that one provision of Representative Biggert's bill, extending certain law enforcement authority to the HHS IG, is inconsistent with legislation that the Department of Justice has proposed, which would extend such authority to IGs on a government-wide scale. We look forward to working with you to ensure that this issue is addressed effectively.

CONCLUSION

Preventing fraud and keeping unscrupulous providers out of the Medicare program is one of our top priorities. Over the past several years, we have greatly intensified our efforts in this area, and have significantly enhanced our program integrity operations.

We appreciate your interest in facilitating our program integrity efforts, particularly Representative Biggert's Medicare Fraud Prevention and Enforcement Act, and hope our input is helpful. We look forward to working with you to strengthen our ability to pursue a zero tolerance policy for fraud, waste, and abuse. Thank you for the opportunity to discuss this important matter, and I am happy to answer your questions.